Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: KULM MEDICAL PA P.O. BOX 430 ROWLETT, TX 75030	MFDR Tracking #:	M4-09-7681-01
Respondent Name and Box #: DALLAS ISD REP. BOX #: 42		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as noted on the Table of Dispute Services: "CPT Code 99212-25 was denied as global to 98940. Please note a -25 modifier was used to denote a separately identifiable procedure which is allowed per NCCI edits. Please see attached NCCI edit for 98940-99212."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $53.04*
3. CMS 1500s
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "No allowance is recommended for procedure code 99212-25 for date of service May 19, 2008. The use of modifier 25 requires documentation indicating a significant separately identifiable evaluation and management service was provided. However, there were no medical records submitted for May 19 justifying the use of this code. One set of medical records does not have a legible date. However, the provider has indicated it was for code 99214, which was billed for date of service May 12, 2008. An additional allowance of $15.00 is recommended for procedure code 99080-73."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
05/19/08	CPT Code 99212-25	1 – 2	$0.00
Total:			$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 134.203, titled *Medical Fee Guideline for Professional Services,* effective for professional medical services on or after March 1, 2008, set out the reimbursement guidelines.

* The Requestor withdrew date of service 06/02/2009, CPT Code 99080-73 as payment was received.

1. These services were denied by the Respondent with reason codes:
   - 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. * Service(s)/Procedure is included in the value of another service/procedure bill on the same date*.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
2. Per Division Rule at 28 TAC Section 134.203(b) code set 99212-25 and 98940 are not considered global if modifier -25 is attached to the evaluation and management code. However, the Requestor did not include the office visit report for the disputed date of service of May 19, 2008 to support the services were rendered as billed; therefore, reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section 413.0311
28 Texas Administrative Code Section. 134.1, 134.203
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor III Medical Fee Dispute Resolution	August 17, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.